THE HAMPDEN HIPPOCRAT

The Hampden District Medical Society Newsletter

Winter 2000 VOLUME 2 Page 1

President's Message:

"Recurrent Theme"

by Claudia L. Koppelman,M.D.

By the time my message is read the twenty first century will have begun. What brave new worlds will be discovered? Which truths shall be uncovered? Whose social values will prevail? Will practicing the "Art of Medicine" survive or fail?
Our minds may be filled with thoughts of anticipation and expectation for something wonderfully different, or apprehensive about the unknown.
Some may be anxious regarding Y2K technology, others on a more mystical level about psychic predictions and yet most of society probably hasn't thought past New Year's Eve.
But that does not stop the continuum of time.....

As I was writing this message I realized why the presidency is usually only a one-year term.
Without being redundant it is difficult to be eloquent with one's ideas when change is slow to follow.
Therefore, instead of looking forward to the horizon perhaps there are lessons yet to be learned from the past.

Welcome to "Civilization 101".
Civilization is defined:
as a society which has an advanced stage of development in the arts and sciences and social, political and cultural complexity.
If we assume that the intelligence of such a society would continually strive to further develop itself then at what point does advancing development destroy the civilization itself or perhaps destroy other civilizations that are in its path?
Furthermore, what happens when micro-civilizations within a society become a driving force towards destruction?

Setting aside natural disasters, which one may argue are in fact partially caused by advancing development....throughout history a central theme recurs.

The untamed human behaviors of being selfish, disrespectful and greedy along with the emotions of fear and those borne of ignorance are the driving forces that have repetitively through the ages brought destruction.
Man's overwhelming instinct to be the superior of another underscores every war that has ever occurred and every suppression of a people throughout time.
For example, white mans arrival in the Americas brought not only the destruction caused by diseases, but through those untamed human behaviors caused the destruction of the Great Indian Nations.
The white man knew what was best, after all they were more civilized"... or were they?
The Indians knowledge of nature's balance was ignored and even today goes unheeded.
The most important lesson being the concept that we have not inherited the earth from our ancestors but are borrowing it from future generations.
When we are born our hands are closed, as if we are grasping onto life, but when we die our hands are open saying I take nothing with me.
When we destroy a part of the whole we risk total destruction.

If you will, the business community can be considered a society within a society, or what I will term a micro-civilization.
When untamed human behaviors are allowed to control the actions of such an entity a domino effect occurs which has the very real potential of leading to the demise of a civilization.
When a society develops itself to become so complex that the complexity in and of itself is contradictory and no longer equitable, with a micro-civilization in control, untamed
human behaviors flourish.
I believe we are presently living at one of those potential turning points in time, where continued disregard for the panoramic effect micro-civilizations are creating in our society will lead to our global destruction.
The disparity within our society continues to increase.
Societal morals and values are skewed de-emphasizing education, rewarding blame and sensationalizing the news.
Truth is no longer verifiable, as definitions, rules and laws are written with as many loopholes as a piece of Belgium lace.
Violence escalates along with stress levels of daily living. The first Amendment goes unchallenged and children are killed in schools and churches while the media and entertainment micro-civilizations continue to portray violence as commonplace occurrences.

For the medical community, the message is clear when practicing medicine is more about numbers, codes, profits and paperwork... rather than patients.
The message is clear when physicians have to hire lawyers and threaten insurers with litigation and triple damage awards just to receive reimbursement on clean claims.
The message is clear when more money is being spent trying to save healthcare dollars than money spent treating patients.
The message is clear when our government encourages on a massive scale our patients to report physician fraud and abuse as if physicians are to be distrusted and equated to criminals

stealing from our government.
The message is clear when you need to hire a private duty nurse to assure proper nursing care when you are hospitalized because understaffing is standard operations to save on overhead costs.
The message is clear when senior nurses are being replaced by young inexperienced nurses because salary differences saves money.

The message is clear when saving healthcare dollars translates into profits for a micro-civilization at the cost of lives, at the cost of the future, at the cost of the House of Medicine.

My philosophical view of watching history repeat itself may move some of you to think next time you have to sign a contract, you'll read it and actually cross out the soul selling clauses.
Perhaps my words will echo in your head next time you're mandated to do more for less, or an insurer pushes their paperwork responsibilities into your office, you'll refuse.
You became a doctor in the first place and you'll stop allowing the outside world to come between you and your patients.
And maybe, just maybe these words will be the message that inspires you to get involved before it's too late.

When I accepted the nomination to be an Officer back in 1997 I wrote:

There are times when I have visions of being in the mountains surrounded by nature. In the quiet whispers of the wind secrets of life are learned by observing and listening.

To feel the rhythm of nature and to experience the balance achieved one must be cognizant of the intricacies and the inherent fragility which exists in the environment.

To merely acquire wisdom and not attempt to effect change is to remain in the mountains.

I must admit it would have been easy to remain in the mountains this summer.
As I kayaked, hiked and hunted for rocks the world of medicine was somewhere else. Time was not rushed.
Artistic creative endeavors produced one of a kind articles of clothing and accessories. The hardest challenge I faced was working with leather.
I liked not being stressed,
Not having to deal with the demands of being more than just a physician to satisfy everyone else's rules and requirements.
I liked not being stressed,
Just trying to retain my principles of truth and fairness.
I liked not being stressed,
Not having to defend my medical decisions to non- physicians.
I liked not being stressed,
Not arguing for reimbursements from insurers who never seem to have received the claims, until they are sent certified.
I liked not being stressed,
By the ever growing and needless complexity of rendering healthcare created by multiple levels of self propagating entities.
I liked not being stressed,
Trying to convince others of visions that could change the future in a positive way by organized medicine.
Although I liked not being stressed, I also knew with a renewed inner balance I had to return from the mountains to continue to advocate for patients and the medical profession, while continuing to practice

My art, the way I was trained, guided by the wisdom of The Hippocratic Oath.
I shall continue to work doing what I truly love doing most, helping others by practicing... "The Art of Medicine", while hoping... that sooner rather than later enough physicians, patients and politicians will want to balance our civilizations' scales so that "history does not have to repeat itself."

To heal one needs to feel
To feel one needs to listen
To listen one needs time
Time allows one to share
To share is to care...
...and caring heals.

Claudia L. Koppelman, MD
President HDMS 1998-2000

Suzanne Skibinski, *Executive Director*
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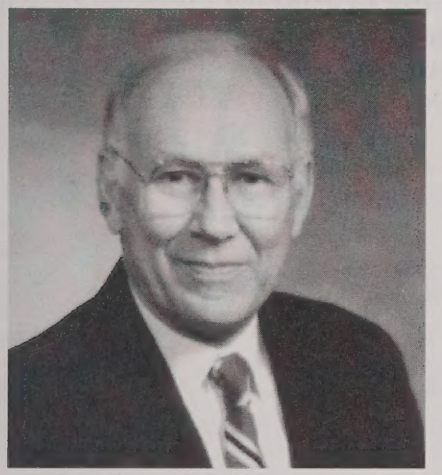
HIPPOCRAT NEWSLETTER EDITOR: President, Claudia L. Koppelman

Randolph D. Smoak, Jr., M.D. to be 155th President of the AMA



Randolph D. Smoak, Jr., M.D., a surgeon from Orangeburg, South Carolina, was elected President-Elect of the American Medical Association (AMA)Board of Trustees in June 1999. He had served as the AMA's Board Chair from 1998 to 1999, Vice Chair from 1997 to 1998 and Secretary - Treasurer from 1995 to 1997. A member of the Board of Trustees since 1992, Doctor Smoak has been a member of its Executive Committee since 1994. He had served as Chair of the Compensation Committee from 1997 to 1998, Chair of the Finance Committee from 1994 to to 1997, as Secretary - Treasurer of the AMA Physicians Health Foundation from 1992 to 1993, and as Chair of the Board's Subcommittee on Membership from 1993 to 1994. Doctor Smoak currently chairs the American Medical Accreditation Program (AMAP) Governing Body, and as lead spokesman for AMA's anti-smoking campaign, he represents the AMA on the Department of Health and Human Services Interagency Committee on Smoking and Health. In addition, he continues his service as an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) since 1996 and AMA's official representative to the National Health Council since 1994.

Prior to his service on AMA's Board of Trustees, he served as alternate delegate to the AMA House of Delegates for the South Carolina Medical Association (SCMA) in 1983, and as a delegate in 1987. Serving on the American Medical Association Political Action Committee (AMPAC) Board since 1984, he was elected Secretary in 1986 and Chair in 1988. He had worked with the Council on Legislation as the AMPAC observer since 1988.

Doctor Smoak's dedication to organized medicine has been evident through his years of service on the state level. Since being elected to the SCMA Board of Trustees in 1972, he has served in virtually every leadership position including President of the SCMA, Chair of the SCMA, Chair of the South Carolina

Political Action Committee, President of SCMA Members/E Insurance Trust and President of the South Carolina Medical Care Foundation. Doctor Smoak is a founding member of the South Carolina Oncology Society and is currently serving as Governor from South Carolina to the American College of Surgeons. He is also an active member of the Southeastern Surgical Congress, the Southern Council of Clinical Surgeons, the Society of Head & Neck Surgeons, the South Carolina

Surgical Society and the South Carolina Chapter of the American College of Surgeons.

Born in Bamberg, South Carolina, Doctor Smoak received his BS degree from the University of South Carolina (USC) and his MD degree from the Medical University of South Carolina (MUSC). He served his internship at Grady Memorial Hospital in Atlanta, Georgia, and completed his residency training at the Medical University of South Carolina. Doctor Smoak completed his senior surgical oncology fellowship at the University of Texas MD Anderson Hospital and Tumor Institute in Houston, Texas. He then returned to his home state to establish a surgical practice.

Doctor Smoak is a fellow of the American College of Surgeons and a diplomat of the American Board of Surgery. He is a clinical professor of surgery at MUSC and clinical associate professor of surgery at the USC School of Medicine. He is the Past Chair of the Department of Surgery, Chief of Staff and Trustee at the Orangeburg Regional Medical Center.

Doctor Smoak's involvement in civic activities includes service as President, South Carolina Division of the American Cancer Society; Lt. Governor, Kiwanis Club; a member of the Board of Directors of the Orangeburg County Chamber of Commerce; and a member of the Board of Directors of the Orangeburg Chapter of the American Red Cross. He has also served on the Cancer Advisory Committee of the South Carolina Department of Health and Environmental Control and as Chair of the Statewide Health Coordinating Council.

Doctor Smoak and his wife, Saundra, have four daughters and reside in Orangeburg, South Carolina.

Mark Your Calendars...

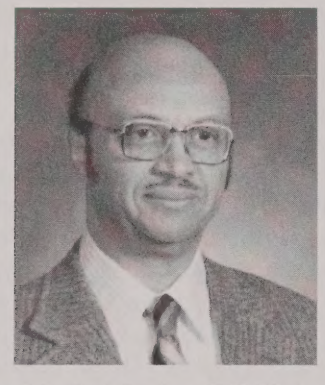
Tuesday January 25, 2000
6:00 p.m.

HDMS Winter District Meeting
Springfield Sheraton
Join your colleagues, State Representatives and Senators, MMS Officers and Members of your New England AMA Delegation in welcoming Dr. Smoak to Hampden District Medical Society and Western Massachusetts.

"Healthcare in the New Millennium"
CME credit, 1 Hour in Category 1
Risk Management

(Please call the District Office to make reservations at: 413- 736-7301)

Hampden District Medical Society's 1999 Senior Volunteer Physician of the Year



The Massachusetts Medical Society (MMS) has added ***Alonzo D. Sheffield, M.D.*** to the distinguished ***Honor Roll Roster of the MMS Committee on Senior Volunteer Physicians.***

Doctor Sheffield has diligently offered his assistance to the residents of the City of Springfield as an active consultant with the youth STD project and medical advisor for the Department of Health and Human Services, youth health services at St. John's Congregational Church, Brotherhood Community Organization.

Doctor Sheffield has been a steadfast member of the Public Health Recognition Committee for Health & Human Services, Hampden District House Calls Program and the MMS Committee on Student Health and Sports Medicine.

The Hampden District Medical Society extends its sincerest thanks to Doctor Sheffield for his service to his community as a dedicated physician and volunteer for 41 years.

Congratulations Doctor Sheffield!

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The Scholarship Committee of the Hampden District Medical Society has voted to award the sum of $1,000.00 to the following medical students:

Hemant Gupta - *Freshman*
University of Massachusetts Medical School

Christy J. Szafranski - *Freshman*
University of Massachusetts Medical School

Bingh N. Truong - *Senior*
University of Massachusetts Medical School

Scott J. Korvek - *Junior*
Boston University School of Medicine

Jonathan E. Abel - *Sophomore*
University of Health Sciences
College of Osteopathic Medicine

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Dr. Max & Ida L. Millman Foundation Scholarship Program Recipients:

Joseph P. DeAngelis - Freshman
University of Massachusetts Medical School

Colin B. Devonshire - Sophomore
University of Massachusetts Medical School

Jeffrey W. Henderson - Sophomore
University of Health Services
College of Osteopathic Medicine

Robin B. Levenson - Freshman
Indiana University School of Medicine

George C. Sakellis - Junior
University of Massachusetts Medical School

Karen M. Scott - Junior
University of Massachusetts Medical School

A "Thank you letter, to the District"...

This letter is to express my gratitude to you and the Committee of the Dr. Max and Ida L. Millman Foundation for your generosity in awarding me the Millman Scholarship. It is a tremendous honor to be awarded this for the 1999-2000 academic year.
I am currently a second year student at UHS. I am a busy member of many clubs, including a Docs for Tots tutor, a Teaching Assistant for the Osteopathic Department, and a member of Sigma Phi, the national Osteopathic Honor Society. I plan to enter into a pediatrics or internal medicine residency upon completion of my rotations. I then plan to establish a practice in New England. Again, thank you very much for your generosity. Your donation has made the achievement of my goals and future plans much easier.

Sincerely Yours,
Jeffrey W. Henderson

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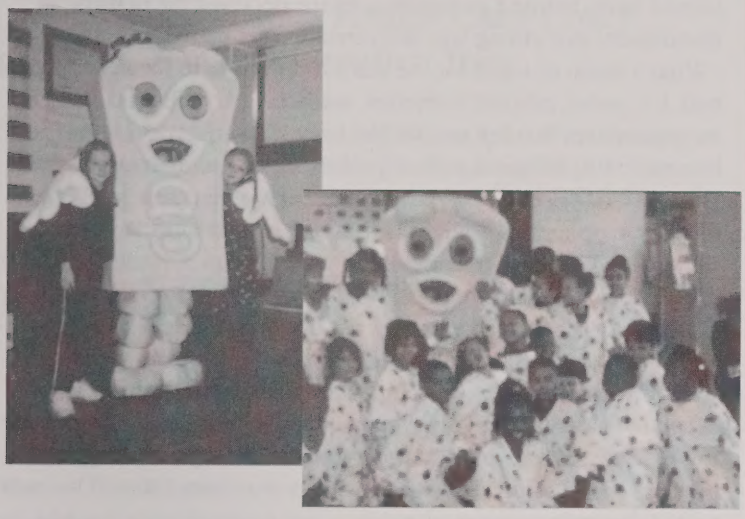
Contributions to the Hampden District Medical Society Scholarship Fund would be most welcome...Through your generosity, HDMS will be able to continue helping medical students.

Please make donations out to:
HDMS Scholarship Fund
and mail to:
Hampden District Medical Society
1111Elm Street, Suite 22
West Springfield, MA 01089

HDMS acknowledges a donation from Kevin P. Moriarty, M.D. Our sincerest thanks for your generosity, Doctor Moriarty.

"SUPER SOAPY"
Visits Eight Area Schools



The Hampden District Medical Society invited "Super Soapy", the Massachusetts Medical Society School Hand Washing Program's Mascot to visit Western Massachusetts recently:

"Super Soapy" instructed the children on proper hand washing technique and its importance for staying healthy.

"Super Soapy" visited classes at Lincoln School, Sabis, White Street School and Grena in Springfield, Belcher School, Bowe and St. Stanislaus School in Chicopee and Our Lady of Perpetual Help in Holyoke. "Super Soapy's" visit was such a huge success "Super Soapy" will be returning to Western Massachusetts to visit additional area schools in the near future.

Save This Date!
May 2, 2000

HDMS Annual Meeting will be held on **Tuesday, May 2, 2000** at the Delaney House in Holyoke.

This is a meeting not to be missed. Join your colleagues in honoring HDMS 50 Year Members, hear the concluding speech of Dr. Koppelman's Presidency, welcome K.V.R. Mohan Rao, M.D. as he becomes HDMS 's next President and get prepared to share an exciting evening with Mr. Stuart Whitehurst and his **"Antique Show and Tell".**

Mr. Whitehurst, from Shinner's Auction House, will be offering appraisals, share knowledge, and answer audience questions in a most delightfully entertaining manner.

So, dig into your attics and cellars, find one item you think may be valuable or have no idea what it is and bring it along for this fun filled evening! ***(Please, no jewelry, stamps or coins...)***

AMA INFORMATION

The AMA has created a **"From the President"** section on its **Web site** to serve as the primary source on the internet for news and information about the presidency of Thomas R. Reardon, M.D. Here, visitors will learn about Doctor Reardon's agenda, his viewpoints and his activities as he leads the AMA through 1999 and 2000. The site provides an important strategic toll that allows Doctor Reardon and future AMA presidents to communicate messages to as wide an audience as possible. The "From the President" section of the AMA Web site can be found at:

http://www.ama-assn.org/presiden.htm

The **American Medical Association (AMA)** is looking for up-and-coming physician leaders to participate in the ***AMA/Glaxo Welcome Emerging Leaders Development Program*** to be offered in conjunction with the ***AMA's National Leadership Development Conference (NLDC)*** on Saturday, March 25, 2000.

Participants will also participate in other skill-building sessions offered during the NLDC, March 26-28, 2000.

Please call the Hampden District Medical Society office at 413-736-0661 for more information and an application.

Calling for nominations for the:

"Dr. Nathan Davis Awards in International Medicine and Public Health"

The AMA will present these awards in two categories: Outstanding International Physician, and Outstanding Global Health Initiative.

The Awards will consist of an engraved piece commissioned exclusively from the internationally recognized Stueben Company, and a grant of $50,000 for each recipient to continue the outstanding work for which they are being honored.

The Awards will be presented at a black tie gala to be held in Chicago on Saturday, June 10, 2000, in conjuction with the AMA's annual meeting.

Please contact Suzanne Skibinski at the HDMS office for nomination procedure information. 413-736-0661

MMS CALL FOR NOMINATIONS

The Committee on Nominations is currently considering candidates for nomination for the following offices: President-elect, Vice President, Secretary- Treasurer, Assistant Secretary- Treasurer, Speaker, and Vice Speaker.
If you and/or one of your colleagues would like to be considered for nomination for one of these offices, please contact the HDMS office for information at 736-0661.

"Hippocrat" Member
Spotlight on

Thomas E. Judd, M.D.

"Hospice helps ease suffering..."
by Barbara Bernard, Union News
(re-printed with permission of writer)

"How odd that the simple definition of hospice - "providing comfort and quality of life to the terminally ill and their families" - is misunderstood by many.

When we knew my husband was not going to survive, we did what he and I always said we wanted to do...be in our own home for as many weeks as we had left. I know that is not always possible for everyone. I make no judgment of those who opt for other ways.

We had added a large sitting room to our bedroom a few years ago, and with its sunshine streaming in four windows from morning to late afternoon, and with me able to be with him at night as well as day, it was ideal. George was adamant that he didn't want a lot of people hovering around. We turned to Hospice, a local program which is part of the Visiting Nurse Association.

Nancy, a Hospice care representative, made arrangements for Beverly, a nurse, to come to our home prior to my husband's hospital discharge to determine what he would need. Drs. Judd and Mazza recommended what George should have, before I picked him up (he declined the offer of an ambulance) everything was delivered and set up in our home.

What a sense of relief for me that I didn't have to locate a hospital bed, I.V. poles, tubings, catheters, medicines, etc. Beverly taught me procedures that lay people like myself can do, and I had become pretty efficient at George's shampoos, shaves and baths. Beverly came each day to provide the high-tech nursing skills and to order supplies that I might be running low on. Often it was I who needed Hospice attention for reassurance that I was doing a good job.

George was expected to live about three days. He was with us almost three weeks, and all that time he had the quietness he wanted with just our two daughters, son-in-law and grandchildren. When they weren't here they phoned daily, and all of us shared the joy of fluffing his pillows, talking to him, kissing him, hugging him and reminiscing about all the things we always shared but now seem to be even more precious.

I will be eternally grateful to Dr. Judd, who, in this era of "who ever heard of house calls," came daily to monitor George and to be there as a supportive, caring physician. I hope God didn't throw away the mold when he made Tom Judd. One morning George told Dr. Judd that he loved him, and Dr. Judd said that was one of the nicest things he had ever been told. Taking George's hand, he said, "George, it's been an honor to care for you." This was the closure for these two remarkable men.

Hospice was non-intrusive. As fragile as George had become, he was still heavy to move. Aldea, a Hospice aide, came to bathe him and do the impossible job of changing bed linen with a patient in bed. When our family wanted to attend Mass on our 50th wedding anniversary, Betty, a Hospice volunteer, stayed with George for an hour. When I hit a panic, Hospice was a phone call away to talk me through the crises. Hospice nurses Marie and Karen filled in on the days Beverly had off. Carol, the bereavement counselor, is there if I ever need to call her.

Only God makes the final judgment, but Hospice helps make a trying period more endurable, adhering to the wishes of the patient and his family. I hope readers will financially support this program, and if it is ever needed for a loved one, do use it. It made what could have been a lonely, terribly sad time for my husband and our little family, a peaceful, beautiful closing to his life. George died at our home, in my arms, with our daughter Nancy, holding his hand."

The Hampden District Medical Society commends ***Thomas E. Judd, M.D.*** *for his outstanding compassion and commitment to his patients...*

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1st Annual Massachusetts Health Care Proxy Proclamation Day

The 1st Annual Massachusetts Health Care Proxy Proclamation program proclaiming the day after Thanksgiving "Health Care Proxy Day" was held in Springfield on November 12, 1999 sponsored by HDMS and the MMS.
Mayor Michael J. Albano issued a proclamation designating the day after Thanksgiving as "Health Care Proxy Day" in the City of Springfield.

The Massachusetts Medical Society's Committee on Advance Directives initiated a resolution promoting the idea of recognizing this day as Massachusetts Health Care Proxy Day which was adopted as MMS policy at our Annual meeting last May. The Goal of this initiative is to raise awareness about the importance of advance care planning and increase the number of people in Massachusetts having health care proxies.

Massachusetts is one of only three states that recognize health care proxies but does not recognize living wills (in which you specify, in advance, medical treatment that you would or would not want in the event that you are unable to express your wishes).

This "Health Care Proxy Day" was the first of what will be an annual statewide effort to help publicize the need for people to designate someone they trust to be their health care proxy, to ensure that the physician rendering your medical care is not alienated from your wishes and decisions in the event you are unable to communicate them yourself.
For more information and to obtain informational packets produced by the MMS, please call (800) 843-6356 or visit website, www.healthcareproxy.org.

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Fifteenth Annual Medical Ethics Seminar Addresses: Communication at the End of Life

Winthrop F. Whitcomb, MD

It is widely known that there is room for improvement in the care of patients near the end of life. The findings of the landmark SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) Study, first published in 1995, corroborate what many healthcare providers and laypersons have observed - that patients often spend their last days in pain and exposed to life sustaining treatment against their wishes.

In an effort to assist individuals in providing appropriate care for dying patients, the Hampden District Medical Society Medico-Religious Committee sponsored a program exploring methods to improve communication between healthcare providers, patients and families at the end of life. The Fifteenth Annual Medical Ethics Seminar, titled, "Improving Communication Skills for Providers of End of Life Care," included presentations by two national experts in the field followed by an interactive segment where attendees discussed cases and practiced skills in small groups.

Connie A. Jastremski, BS, MSN, Assistant Professor of Nursing, State University of New York at Syracuse opened the seminar by providing a compelling overview of "End of Life Care" in the United States followed by a discussion of a protocol for giving bad news excerpted from the book, "How to Break Bad News" by Robert Buchanan (Johns Hopkins University Press). Ms. Jastremski concluded with four principles of advance care planning: 1) Do it before the crisis 2) Plan for events near death 3) Rehearse and 4) Don't forget family aftercare.

The second hour saw Thomas J. Prendergast, MD, Assistant Professor of Medicine at Dartmouth Medical School and Chief of Pulmonary Medicine, White River VA Medical Center present strategies for building consensus between parties around the end of life. Dr. Prendergast is a pioneer in applying negotiating techniques long used in business to medical situations, especially in the care of the dying. His presentation and case analysis was based largely on the work, "Getting to Yes" by Roger Fisher and William Ury (2nd Ed, New York: Penguin Books, 1991). Using a case for illustration, the four negotiating principles he discussed were: 1) Separate the people from the problem 2) Focus on interests, not positions 3) Invent options for mutual gain and 4) Insist on using objective criteria.

The seminar, held in the Deliso Center at Mercy Hospital, was attended by approximately 150 individuals, nearly all of whom felt the program was well presented and fulfilled a need, given the paucity of training in the area of communication. Earlier in the day, the two speakers offered a lively discussion for a large audience at Baystate Medical Center under the direction of Daniel Teres, MD. The evening program was supported by a generous grant from Purdue-Frederick Pharmaceuticals.

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Pediatricians & Family Practitioners

Please note:

PARENTS HELPING PARENTS

(formerly Parents Anonymous of MA)

1-800-882-1250

We can put parents in touch with other moms and dads who are learning together to be better parents. Please have this number available to any parent in need of support ...we're here to help.

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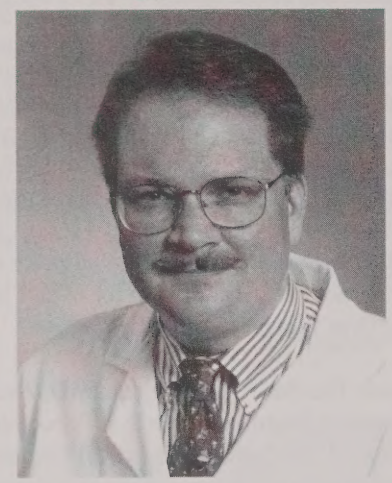
New Medical Staff President



Kevin Schmidt, M.D. has been named to a two-year term as President of the Mercy Hospital Medical Staff. Doctor Schmidt is a magna cum laude graduate of the Boston University School of Liberal Arts, where he majored in medical science. He earned his Doctorate of Medicine from the Boston University School of Medicine, performing his internship and residency in internal medicine at the Veteran's Administration Medical Center in Boston.

He specializes in Internal Medicine, Schmidt Diagnostic Medical Group, Pioneer Valley Physicians, LLP, 300 Stafford Street, Springfield, on the Mercy Hospital campus.

Doctor Schmidt's extensive teaching experience includes service as a senior clinical instructor at Tufts University School of Medicine, career advisor for Springfield, College, and relevance reviewer for the American Board of Internal Medicine.

He is a member of numerous professional organizations, including the American College of Physicians American Society of Internal Medicine, the American College of Medical Quality, the American Medical Association, Massachusetts Medical Society and the Catholic Medical Association, and is a medical advisor for the Permanent Observer Mission of the Holy See to the United Nations.

A resident of Wilbraham, Doctor Schmidt is active on the town's Advisory Board of Health and with the Wilbraham Ambulance Society. His civic involvement also includes service as medical director and trustee of St. Michael's Residence of Retired Priests, and membership in the Knights of Columbus and the Pontifican American .

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An Educational Program: Science-By-Mail

Science-By-Mail is a national hands-on science program for grades 4-8 that teams children with scientists who volunteer as pen-pal mentors. The children enrolled in this program receive two thematic "challenge packets" in the mail and work to complete the activities with the encouragement and advice of their mentors.

Science-By-Mail was created by the Boston Museum of Science and the National Science Foundation in 1988, and today are run in partnership with Kendall/Hunt, a national publishing company. Since then, more than 200,000 children and 14,000 scientists have participated across the country and around the world. This program was designed to provide an engaging and relevant vehicle for exploring science and developing problem solving and critical thinking skills, as well as a means to reach typically under-served populations such as girls and minorities.

I have been involved with this program for several years as a pen-pal scientist. As a medical technologist in a clinical microbiology laboratory, I have the opportunity to link the disciplines of science and laboratory medicine in my correspondence with children. I have worked with classroom groups, home school students, and scout troops from across the country and as distant as Kenya. I am currently assigned to students in Texas, Pennsylvania, New Hampshire and Massachusetts. The children are consistently interested in my education, my job duties and how I became interested in my field, as well as personal aspects. I have also had the opportunity to visit pen pals in the classroom and conduct a tour of the laboratory for a home-school group. I feel that being a pen-pal scientist has given me the opportunity to stimulate a child's interest in science, to change the stereotype of who a scientist is, and to show that scientists are real people with interesting jobs and backgrounds.

The Science-By-Mail program needs more volunteer scientist pen pals every year. Contact the Science-By-Mail program at the Museum of Science, Science Park, Boston, MA 02114 or call 1-800-729-3300 for more information.

Roslyn Ashley Carkhuff BSMT(ASCP)
Microbiology Services
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

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Important Notice to All Physicians...

Free Drug Assistance Programs for Indigent Patients

Assistance for patients and doctors is available through the Serving Health Information Needs of the Elders (SHINE) Program.
For more info call: 1-800-882-2003 / TTY: 1-800-872-0166

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Arthur A. Pava, M.D. has recently retired from his practice in neurosurgery. He received his medical degree from Yale in 1951 and has practiced at Baystate Medical Center and Mercy hospital.

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Correction:

Demosthenes Dasco, M.D. has informed the Hampden District Medical Society that he is still in practice and seeing patients at: 80 Congress Street, Springfield, MA 01104 (413) 781-5050

"Massachusetts Would Save with Single Payer Reform"

Summary by: H. Douglas Barnshaw, M.D.

Two studies commissioned by the MMS show that the state could save between $170 million - $1 billion a year by implementing a single payer system which at the same time would provide universal health coverage.

The full results of the study by the Lewin Group in Fairfax, Virginia, and researchers from Solutions for Progress in Philadelphia, and a study by the Boston University School of Public Health, are available online at www.mms.org/physician/resource/lewin.html or call the MMS at 800 -322-2303.

The Solutions/BU report is 55 pages long and compared: 1) our current system; 2) a universal comprehensive system with simplified administration plus cost sharing that is co-pays and deductibles; and 4) extending today's HMO, PPO or POS coverage to all, without other reforms.

Number two and three alternatives include medications, long term care, workmen's comp medical expenses, medical expenses for automobile accidents, and the usual full range of health services.

The projected total (includes out of pocket expenses) spending without reform #1, is estimated at $36 billion in '99.

Alternative #2 would cost $34.5 billion; #3 would cost $35.7 billion and #4 would cost $39 billion.

The universal access with comprehensive coverage would reduce total health spending by $1.6 billion, increase spending for actual medical services, eliminate out-of-pocket spending and reduce administrative cost by $3.5 billion.

This system would restore trust between patients and doctors, and put the focus on **quality comprehensive care for all at reasonable costs.**

The report gives references to where and how it obtained the data. Much of the report is devoted to clarifying where the savings will come for the universal, comprehensive with simplified administration system. It does not say how we could get to this system, or what the organization would look like to administrate this system, but does list what the responsibilities would be.

The Lewin Report is 8 pages and only focuses on the cost for a "single payer system". It takes data from the Congressional Budget Office, and does not give any other references. It projects the costs for the single payer system as being higher initially and then less than our current system by the year 2005. The report has little discussion.

The difference in the two predictions is not because of different coverage, but because of different assumptions and predictions as to savings.

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Commentary:

A **Just, Fair** Medical System for Massachusetts Residents Is it Possible?

The Massachusetts Medical Society (MMS) says that such a system should provide comprehensive coverage for all at a reasonable cost, with quality maintained. Many would like to see choice of physician and hospital reinstated and long-term care provided.

People have said such a system would cost too much, but the studies sponsored by the MMS demonstrate that a single payer system would provide the desired coverage and save money!

The "Committee to Defend and Improve Health Care" is seeking signatures for a petition for a ballot that would create a special committee of the Massachusetts Legislature, health providers, advocates, and citizens to create a system that would provide universal access and coverage for all Massachusetts residents. The ballot would put into effect a patient's "Bill of Rights and Protections" including the right to see a specialist, have a second opinion from a provider of the patient's choice plus other provisions, and a moratorium on *for profit* conversions of *not for profit* organizations until universal coverage is obtained. (Please fax 617-354-1961 for more information.)

A second organization, "Mass-Care", is advocating for a "Single Payer Universal Health System". This organization points out that to obtain the goal of comprehensive coverage for all and hold on costs, we need a single payer system. Having said this there are many "details" to be decided about how this system would look which will make all the difference. Those who are involved early will have a bigger say. (Call 800-383-1973 for more information.)

Mass-Care and others have sponsored a bill, "Massachusetts Health Care Trust Legislation", which was introduced December 2, 1998 as Senate Bill #531 and House Bill #1947. This bill would set up a committee to design a comprehensive universal medical coverage plan with a single payer. The bill is in the Joint Health Committee and is on the agenda for January. Mass Care hopes they will establish a committee to study ways to implement a single payer system.

The MMS, at their fall meeting, designated the Committee on Medical Service to study ways to implement a single payer system.

More and more physicians, patients, and businesses are becoming increasingly dissatisfied with our medical system. We can create a better system for patients, providers, and our families. Get involved and advocate for what you think is fair and just.

Douglas Barnshaw, M.D.
HDMS Public Health Committee Member

Outdates - Where are they?

By Richard Pieczarka, LPN, RT, CIC
Infection Control Practitioner, BMC

Billions of dollars in patient care supplies are purchased in the United States each year. Many of these items have expiration dates stamped on their labels by the manufacturers. These dates are to insure both the integrity of the product and to guarantee that there is a reasonable time period before microbial contamination occurs.

Examples of items that are stamped with expiration dates: eye solution bottles, IV solutions, swabs, biological test strips for sterilizers, medication vials and ampoules, blood specimen tubes, culture bottles, lab test strips, patient kits and the list goes on and on.

State Departments of Health and professional organizations in the medical arena have standards that prohibit the use of expired items in patient care.

There needs to be a written policy to address product stocking and removal. All dates on medications, IV's and sterile supplies must be checked prior to use. If no date is indicated, the item is considered sterile until opened or contaminated. Dated products are not to be used after the indicated expiration date. If only the month and year are indicated, the product will be considered outdated on the last day of the month. When stocking new supplies a rotation of supplies is necessary to insure that older (but not outdated) stock will be used first.

In designing a practice, it is helpful to include written policies and procedures, which, when implemented, will eliminate the use of outdated products in patient care areas, thereby insuring a safe practice for patients. Another outcome will be saving money by not wasting or overstocking supplies. It would also be wise to implement an area-wide inventory, assigning a staff member the responsibility of ensuring product safety.

Letters Policy

Letters to the editor should be approximately 250 words or less, preferably typed in Word and saved to a disk. The full name and address of the writer along with a signature for verification on a paper copy of the letter must be enclosed. All letters are subject to editing.

Please **mail** them to:

The Hampden Hippocrat
1111Elm Street, Suite 22
West Springfield, MA 01089
or e-mail to: Hampden @massmed.org.

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The "Hampden Hippocrat Newsletter" is the news organ of the Hampden District Medical Society and would like to become the forum for sharing information and opinions amongst the members for whom it is being created. Any article printed expresses the opinion of the author and should not be construed to imply endorsement by the HDMS.

Welcome New Members

INTERNAL MEDICINE
James M Freeman
Deborah J Hoadley
Seth Kuperschmid
Scott A LeBlancWen Yee Lee
Elizabeth Claire Lippitt
Patrick T Mailloux
Michael H O'Shea
Jill L Studley
John Francis Peluso, Jr
Marta Aglaee Quijano-Vega
Sharif Tarazi

PEDIATRICS
James Lee Bockhorst
Stephen C Anderson
Dana Rae Buchanan
Amy C Kasper

GERIATRICS
Jodi P Goh

EMERGENCY MEDICINE
F Craig Sylvester
William Douglas Collins

ORTHOPEDIC SURGERY
Charles A Sommer

ORAL & MAXILLOFACIAL SURGERY
William John Bontempi

SURGERY
Paul Henry Kispert
Michael Vincent Tirabassi

ANESTHESIOLOGY
Susan M Anti

PATHOLOGY
Sugianthi Soundararajan

NEUROLOGY
Timothy Gerard Lukovits
Syed T. Ali

GASTROENTEROLOGY
Peter J. Weinstein

STUDENTS
Jason C. Chung Vinu Verghese

HDMS Sponsored Activities

Committee on Public Health, HDMS Office
Tuesday, February 8, 2000 12:00 Noon,

Executive Board Meeting, HDMS Office
Tuesday, January 18, 2000 6:15 p.m.

HDMS Winter District Meeting, Sheraton Springfield
Speaker: Randolph D. Smoak, Jr., M.D. President-elect, AMA
Tuesday, January 25, 2000 6:00 p.m.
1 CME Risk Management Credit

Grand Rounds Baystate Medical Center
Chestnut Conference Center
Speaker: Randolph D. Smoak, Jr., M.D. President-elect, AMA
Wednesday, January 26, 2000 11:00 a.m.
1 CME Risk Management Credit

Kiwanis Luncheon
Storrowtown Tavern, West Springfield
Speaker: Randolph D. Smoak, Jr., M.D.
President-elect, AMA
Wednesday, January 26, 2000 1:00 p.m.

"SOAPY", MMS Hand Washing Mascot
Greater Springfield Area Elementary Schools
March 2000

Medical Legal Forum (TBD) Spring 2000

Doctors Appreciation Day, March 30, 2000
Carnations to be delivered to various area hospitals and physicians.

HDMS Annual District Meeting,
May 2, 2000, Delaney House, Holyoke
6:00 p.m. "Antique Road Show"

Legislative Breakfast May 5, 2000

"Girl Scouts of Today, Physicians of Tomorrow
June 29, 2000
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Obituaries

January 14, 1910 - August 22, 1999

Nathaniel N. Bennett, M.D., Past-President of the Massachusetts Academy of General Practice and Medical Director of the Western MA Division of the International Ladies Garment Workers Union, passed away on August 22, 1999 in Saint Albans, VT. Doctor Bennett was a member of the AMA, MA Medical Society, Hampden District Medical Society, Esoteric Masonic Lodge and a staff member of the Wesson Maternity Hospital.

March 30, 1921 - November 17, 1999

J. Wallace Morgan, M.D. a former area obstetrician and gynecologist, passed away on November 17, 1999 at home. He was born in Newburg, Fife, Scotland, grew up in Pittsfield and settled in West Springfield in 1951. He graduated from New York Medical College in 1947 and was a member of the Hampden District Medical Society, Massachusetts Medical Society, American Medical Association and the Blandford Country Club. He served as a diplomat on the National Board of Medical Examiners and was a fellow of the American College of Obstetrics and Gynecology.

February 6, 1932 - December 7, 1999

William J. Baker, M.D., of Wilbraham passed away at home. He was a former member and Past-President of the Berkshire District Medical Society. He received his medical degree from Tufts University Medical School and completed his internship and residency at the Naval Hospital in Great Lakes. He was a Vietnam War Navy Veteran and served in the Army Reserve.

So Sorry...
Halina P. Wiczyk, M.D. was inadvertently omitted from the Women in Medicine Roster in the prior issue of the Hampden Hippocrat Newsletter. Our sincerest apologies to you, Doctor Wiczyk.

Clinical Pearls

Thrombocytopenia in the Primary Care Setting

by Zubeena M. Mateen MD, FACP

Definition:
Platelets form aggregates at the site of blood vessel injury and are thus responsible for the primary arrest of bleeding. The normal plt. count is between 150 - 400,000 per microliter. A plt. count below this number predisposes to bleeding. There are few clinical manifestations in the range of 50 - 150,000/ul, unless there is associated platelet dysfunction. Minor spontaneous bleeding and bleeding after surgery are seen on the range 20 - 50,000/ul, with more serious bleeding occurring as the plt. count falls from 20,000 - 0. Even a very low plt. count unaccompanied by bleeding is not an emergency, since many patients tolerate low levels for
prolonged periods without any serious sequelae.

Case Histories:

1. *A 25 year old medical student presents with a one week history of epistaxis . There is no prior h/o a fever or systemic ymptoms. No recent medication intake. On exam she is afebrile. There is no splenomegaly. There are petechiae noted on around the ankles. Labs reveal a wbc of 6.5, hgb of 11.9 gms, a plt count of 5,000. Peripheral smear showed a few giant platelets.*

2. *A 34-year-old lady has a h/o diarrhea for one week. She now presents with mennorrhagia, gum bleeds, and extensive bruising. She also complains of a headache and left flank pain. Exam is significant for a temperature of 100.5 degrees F, blood blisters in the mouth, extensive skin bruising, and abdominal tenderness. The lab data was as follows: wbc - 12,00, hgb - 6.5gms, platelets - 30,000. An active urinary sediment, bun - 40, crt - 1.5. The peripheral smear revealed a lot of fragmented RBCs, reticulocytes.*

These two cases illustrate the important distinguishing characteristics of ITP and TTP. In ITP the platelets (plts.) are destroyed secondary to antibody in the blood stream. This leads to a compensatory stimulation of the bone marrow with resulting outpouring of young hyperfunctional platelets, leading to large platelets on the smear and mild bleeding manifestations.

In TTP on the other hand, in addition to the quantitative deficiency, a platelet function defect is also present. This leads to more severe bleeding complications. In addition, there is fibrin deposition in the walls of the microvasculature that leads to deformity and destruction of the red blood cell membrane and the appearance of erythrocyte fragments (schistocytes) on the peripheral smear.

Pathophysiology:

·Platelets(plts.) arise from the fragmentation of megakaryocytes, which are large, polypoid bone marrow cells produced by the process of endomitosis. After leaving the marrow space, 1/3rd of platelets is sequestered by spleen, while the other 2/3rd circulate for 7-10 days. Normally, only a small fraction of the plts. Mass is consumed in the process of hemostasis, so plts. circulate until they become senescent and are removed by phagocytosis.

The normal plt. count is maintained between 150 - 400,000 per microliter. A decrease in plt. mass stimulates an increase in number, size and ploidy of megakaryocytes, releasing additional plts. into circulation. This process is regulated by Thrombopoietin - binding to its megakaryocyte receptor.

The platelet count varies during the menstrual cycle, rising following ovulation and falling at the onset of menstruation. It is also influenced by the patient's nutritional status and can be decreased in severe iron, folic acid or B12 deficiency.

Clinical Features:

The presenting symptom is bleeding. This occurs mostly at superficial sites such as skin, mucous membranes, or gastrointestinal or Genitourinary systems e.g. easy bruising, epistaxis, menorrhagia and prolonged and excessive bleeding after surgery or dental work. With severe deficiency there may be CNS, GI or GU bleeding.

Classification:

This is based on platelet kinetics: Accelerated destruction, Impaired production, Disordered distribution.

Accelerated Destruction:

In general patients in this class have no splenomegaly or abnormalities of erythrocytes, leukocytes or bone marrow. The prototypic example is ITP. Other disorders include drug induced platelet destruction or associated with infections, like HIV.

Impaired Platelet Production:

Here there is a bone marrow abnormality with resulting decrease in the megakaryocytes and associated abnormalities of leukocytes and red cells are also seen. This is seen with marrow infiltrative disorders e.g. acute leukemias, lymphomas or metastatic carcinomas as well as certain drugs, like chemotherapeutic agents that are marrow suppressive or as an idiosyncratic reaction, e.g., to Chloremphenical, Phenytoin or Sulfonamides. Aplastic anemia would also be covered under this heading.

Disorders of Distribution:

In patients with marked splenomegaly, the size of the splenic pool is increased, with a proportional decrease in the circulating pool. This will frequently lead to plt counts in the range of 30 - 100,000/ul. There is usually an associated leukopenia. The most common causes of hypersplenism are portal hypertension secondary to liver disease and lymphoproliferative disorder. Splenectomy is rarely indicated, unless other mechanisms are also at play e.g. a lymphoma involving the bone marrow.

Possible Etiologies:	***Work-Up:***
Pseudothrombocytopenia	*Repeat plt count in citrate anticoagulant*
Meds:(heparin,sulfonamides, Quinine,quinidine, thiazides, phenytoin)	*Heparin induced antibody test drug induced platlet antibodies*
DIC, TTP, HUS	*PT, PTT, Fibrinogen, D-dimer, PBS*
Immune thrombocytopenia	*H & P, baseline plt. count, Direct plt.antibodies*
Acute infection	*H & P, Cultures, HIV testing*
Primary bone marrow disorder	*H & P, PBS, Bone marrow aspirate and biopsy*
Immunological/Rheumatological vasculitis	*H & P, Serology:ANA, RA*

Management:

Patients with acute profound thrombocytopenia require urgent diagnosis to choose among very different management strategies.

Drug Induced Thrombocytopenia:

This can be severe and unexpected. It often occurs in patients with multiple medical problems who are on multiple drugs, making diagnostic and management decisions difficult.

In the absence of promptly available and clinically validated laboratory tests, judgement about drug-induced thrombocytopenia must continue to be based on clinical criteria. When a physician is confronted by a patient with thrombocytopenia who is taking multiple drugs, the most important issue is to determine which drugs are more likely to cause it to decide which drugs to discontinue first. Referral to the accompanying list may help you to make this decision by providing the relative strength of clinical evidence (See Attached Table).

A new class of agents used in patients with acute coronary syndromes are the plt. glycoproteinIIb/IIIa antagonists. These are increasingly recognized as a cause of thrombocytopenia. This may be acute (within 24 hours) or delayed (Up to 14 days later). Little evidence is presented as to what the underlying mechanism is; though an immune-mediated thrombocytopenia is the leading candidate for a cause.

The first consideration in the management should be to immediately discontinue the drug if the plt. count drops below 100,00u/l . Should the plt. count fall below 20,000u/l a plt. transfusion should be considered.

Immune thrombocytopenia:

Accelerated plt. destruction, predominantly in the spleen is produced after sensitization of plts. by an IgG autoantibody. This is accompanied by marrow megakaryocytic hyperplasia.

In childhood the disease is acute and self-limited. In adults onset is gradual, with spontaneous remissions in only 10-15% of patients. Young women are usually affected. Superficial bleeding does not occur unless the count falls to low levels (less than 5000/uL) since the plts. are large and hyperfunctional. ITP can occur de novo or be associated with HIV, SLE or drugs.

Pregnancy associated ITP:
Gestational thrombocytopenia is the most common type of thrombocytopenia in pregnancy. It is important to distinguish from ITP, because ITP can cause fetal thrombocytopenia whereas gestational does not. The distinction is not easy though more severe thrombocytopnia in early pregnancy indicate ITP.

Treatment:
1. IVIG.
2. PLt.antibody testing is considered unnecessary. Some authorities recommend percutaneous umbilical cord sampling/ fetal scalp vein sampling at delivery.
3. In most cases vaginal delivery is feasible.
4. For infants, repeat plt. count for 3-4 days is recommended If plts. <50,000u/L, brain imaging is appropriate.
5. Management of infant includes IVIG and plt. transfusion, if count <20,000u/L.

Management:
1. Prednisone: If patient's plt. count falls below 30,000u/L, 1mg/kg of Prednisone should be started. It should also be given to patients with plt. count near 50,00u/L who have mucosal bleeding or RF for bleeding e.g. HTN, PUD, or a vigorous life style.
2. About 2/3rd of patients will respond within 3 weeks.
3. For patients with life threatening bleeding, treatment should include platelet transfusion and IVIG.
4. Splenectomy is recommended for refractory disease and one that recurs when steroids are tapered
5. Treatment options for Splenectomy refractory ITP include - IVIG, Cyclophosphamide, Azathioprine, Vincristine and Danazol.

Thrombotic thrombocytopenic purpura:
The presentation and diagnosis of TTP have changed because of availability of effective treatment with Plasma Exchange. TTP was initially defined in 1966 by the Pentad of clinical features:
1. thrombocytopenia.
2. microangiopathic hemolytic anemia
3. neurologic symptoms and signs
4. renal function abnormalities
5. fever

With effective therapy it is now urgent to make a diagnosis, which may mean less stringent diagnostic criteria. Currently only thrombocytopenia and microangiopathic hemolytic anemia are sufficient to establish the diagnosis and initiate Plasma Exchange. Adults with clinical features of TTP but in whom renal failure predominates are described as HUS. It may be preceded by hemorrhagic diarrhea caused by E. coli0157:H7. An association of TTP with HIV has also been suggested.
Differential Diagnosis of TTP includes: SLE, Infection with CMV, aspergillus, or beta-hemolytic streptococcus or menningococcus; disseminated carcinoma; and heparin-induced thrombocytopenia.

Management:
1. Plasma exchange is the cornerstone of treatment and the single most important modality. Plasmapharesis is initiated on a daily basis with a single plasma exchange. The replacement product may be whole fresh frozen plasma or the supernatant fraction from cryoprecipitate preparations. The duration of exchange is empiric; One parameter is a normal plt.count and LDH Level. Mortality of TTP-HUS has improved dramatically from 90% during the era prior to Plasma Exchange to 15-30%
2. Some centers use high dose steroids.
3. Some use antiplatelet agents.
4. The efficacy of additional treatments, such as vincristine, IVIG and splenectomy, remains uncertain.

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Table of drugs causing thrombocytopenia. Relative frequency according to number of reports with definite or probable clinical evidence.

# of Reports	***Drug***
38	Quinidine (Quinigluteâ, Cardioquinâ, & others)
11	Gold (Ridauraâ, Solganolâ, & others)
10	Trimethoprim/Sulfamethoxazole (Bactrimâ, Septra, etc)
3-9	Acetaminophen (Tylenolâ, Panadolâ, & others)
	Aminoglutethimide (Cytadrenâ)
	Aminosalicylic acid (Paserâ)
	Amphotericin B (Amphocinâ, Fungizoneâ)
	Carbamezpine (Tegretolâ)
	Chlorothiazide (Diurilâ, Diurgenâ)
	Chlorpropamide (Diabineseâ,
	Glucamideâ)
	Cimetidine (Tagametâ)
	Danazol (Danocrineâ)
	Diatrizoate meglumine (Urografinâ)
	Diclofenac (Cataflamâ, Voltarenâ)
	Digoxin (Lanoxinâ)
	Hydrochlorothiazide (Aquazideâ, Esidrixâ, & others)
	Interferon alpha (Roferon Aâ, Intron Aâ)
	Methyldopa (Aldometâ)
	Naldixic acid (Negramâ)
	Oxprenolol (Trasicorâ, & others)
	Procainamide (Pronestylâ)
	Quinine (Quinammâ, Quindanâ, & others)
	Ranitidine, (Zantacâ)
	Rifampin (Rifadinâ, Rimactaneâ)
	Sulfasalazine (Vancoledâ)
	Vancomycin (Vancoledâ)
1-2	Alprenolol (Aptin)
	Amiodarone (Cordaroneâ)

# of Reports	***Drug***
1-2	Ampicillin (Omnipenâ
	Amrinone (Inocorâ)
	Captopril (Capotenâ)
	Cephalothin (Keflinâ)
	Chlorpromazine (Thorazineâ, Ormazineâ)
	Deferoxamine (Desferalâ)
	Diatrizoate meglumin/Diatrizoate sodium
	(Hypaque megluminеâ)
	Diazepam (Valiumâ)
	Diazoxide (Proglycemâ, Hyperstatâ)
	Diethylstilbestrol (Stilphostrolâ)
	Difluormethylornithine (eflornithine)
	(Ornidylâ)
	Ethambutol (Myambutolâ)
	Fluconazole (Diflucanâ)
	Glibenclamide (Diabetaâ, Diabineseâ)
	Haloperidol (Haldolâ)
	Ibuprofen (Motrinâ)
	Iopanoic acid (Telepaqyeâ)
	Isoniazid (Laniazidâ, & others)
	Levamisole (Ergamisolâ)
	Lithium (Lithonateâ, Eskalilthâ & others)
	Meclofenamate (Melclodiumâ, & others)
	Methicillin (Staphcillinâ)
	Minoxidil (Lonitenâ)
	Naphazoline (Antazoline-Vâ)
	Nitroclycerine (Nitrogardâ, Nitroglynâ, & others)
	Novobiocin (Albamycinâ)
	Oxyphenbutazone (Californitâ)
	Oxytetracycline (Terramycinâ)
	Phenytoin (Dilantin)
	Novobiocin (Albamycinâ)
	Oxyphenbutazone (Californitâ)
	Oxytetracycline (Terramycinâ)
	Phenytoin (Dilantin)

Piperacillin (Pipracilâ)
Sulfisoxazole (Gantrisinâ)
Sulindac (Clinorilâ)
Tamoxifen (Nolvadexâ)
Thiothixene (Navaneâ)
Tolmetin (Tolectinâ)

Drugs are listed according to the number of reports with definite or probable clinical evidence as defined in Table. All 48 drugs reported to cause thrombocytopenia supported by level I evidence (which includes the criterion of recurrent thrombocytopenia with rechallenge in the same patient) and 15 drugs that were validated by at least two patient case reports with a level II evidence are listed. Within the categories of 3-9 and 1-2 patient case reports, drugs are listed alphabetically.

* *

SNOWBLOWER INJURIES...

By: Jeffrey C. Wint, M.D.

The snow swirls around the porch corner. It is a good storm, the weather says it'll go all day and into the night. While the wind has not died down, its face numbing effect is seemingly halted as the sun peeks out from behind the gray white mass of clouds looming to the west. For although it is an early morning sun, seasonally low in the sky, there is still enough heat on his face to make the task ahead seem palatable. Taking no changes that the morning will be less harsh than it's been all ready, he starts the engine and the snowblower is ready for its season's premiere. The rotors turn and the augers set to work on the heavy wet snow that is now at least 7 inches deep. The added heat of the new day and the extra push needed to keep the intake chute in place tells this experienced operator that the task ahead will be difficult even with this time tested machine. At the end of the driveway the impeller suddenly seizes up. Down at least a hundred yards from the utility shed and the wind is picking up. "Just a quick brush of a finger into the packed snow covered chute and then back to work. This'll probably keep happening all day," he knowingly thinks to himself. Turning the engine off, just in case, the snow is cleared. But several feet later with the sun now glaring off the top of the lawn, the machine clogs again. Machine off, glove on, like a well rehearsed mantra as the man's hand reaches up just a little deeper this time, "Just a bit more to go to clear this damn thing." The machine starts with a jump, "Funny, the engine was off, " he thinks, talking to no one except himself with quick silent thoughts. At first there is just a thud, a tug and a push on his middle finger, then the pain comes, not severe but there from somewhere past his wrist and unremitting just the same. "Damn! My glove got stuck." He pulls it off quickly to check his hand and sees the blood, bone and a grotesque distortion where a fingertip used to be...

Each year in Western Massachusetts and all around the world, people suffer amputations and mutilating injuries of their hands from improperly using a snow blower. The biggest misconception is that the auger located at the intake end of the snowblower poses the greatest hazard. When in fact it is the impeller, a small piece of rapidly turning metal in the exit chute that causes most injuries. As snow clogs the outflow chute, the impeller, whose job it is to send the snow high up into the air, suddenly stops. The operator usually does not expect that there is a chance of injury from clearing a clogged outflow chute. As the finger loosens the snow, the impeller rapidly starts to spin again causing damage to anything that is in its way. Even with the machine turned off, by a seemingly knowing and experienced user there can be torque left in the system and the impeller can still spin rapidly once cleared causing injury. Some machines seemingly have caused injury despite claims that "all safety precautions where followed." Forgetting though the most important one: not placing fingers in the harms way.

Injuries usually occur in males, with an average age of 44 years. The dominant hand is involved in 90% of injuries and the middle finger, being the longest, is involved most frequently. Nevertheless, multiple finger injuries are often seen. The usual injury is amputation or severe injury of the distal phalanx, the part of the finger that includes the nail and the most sensitive part of the finger for touch and manipulation. Injuries can be devastating in terms of medical costs as well as social and economic ramifications.

Amputated parts in general are poor candidates for reattachment or replantation, the crushing avulsing force of the amputation causing irreparable harm to the neurovascular structures that would need to be repaired for survival.

Heavy wet snow averaging greater than 6 inches deep associated with temperatures of 28 degrees Fahrenheit or more are the most common weather conditions associated with these injuries. If sticks or similar devices are used to clear snow, they must be strong enough to avoid fragmentation or eye injuries can result.

Injuries usually occur in males, with an average age of 44 years. The dominant hand is involved in 90% of injuries and the middle finger, being the longest, is involved most frequently. Nevertheless, multiple finger injuries are often seen. The usual injury is amputation or severe injury of the distal phalanx, the part of the finger that includes the nail and the most sensitive part of the finger for touch and manipulation. Injuries can be devastating in terms of medical costs as well as social and economic ramifications.

Amputated parts in general are poor candidates for reattachment or replantation, the crushing avulsing force of the amputation causing irreparable harm to the neurovascular structures that would need to be repaired for survival.

Heavy wet snow averaging greater than 6 inches deep associated with temperatures of 28 degrees Fahrenheit or more are the most common weather conditions associated with these injuries. If sticks or similar devices are used to clear snow, they must be strong enough to avoid fragmentation or eye injuries can result.

Recommendations for safe use of a jammed snowblower:

1. If the snowblower jams, immediately turn it off.
2. Disengage the clutch.
3. Wait 10 seconds after shutting off to allow impeller blades to stop rotating.
4. Always use a stick or broom handle to clear impacted snow. The stick must be strong enough to avoid breakage or eye injuries can result from flying fragments.
5. Never put your hand near the chute or around the blades.
6. Keep all shields in place. Do not remove safety devices on machine.
7. Keep hands and feet away from moving parts.
8. Keep a clear head, concentrate and do not drink alcoholic beverages before using a snowblower.

*Source modified from ASSH information sheet 09/98, "Prevention of Snowblower Injuries"
Patient and Public Education Committee
(American Society for Surgery of the Hand)

MASON-WRIGHT RETIREMENT COMMUNITY

THE ONLY TRULY AFFORDABLE ASSISTED LIVING IN PIONEER VALLEY

One of the most important events to happen in Western Massachusetts is the opening of the FIRST AND ONLY TRULY AFFORDABLE ASSISTED LIVING FACILITY. It is located one block from STCC {State Street} and behind Baystate Hospital and Commerce High School on State Street on the corner of Union and Walnut Streets in Springfield.

Founded in 1897 through a bequest and directive in the will of Primus Mason, the distinguished African-American entrepreneur and philanthropist from Springfield, the Mason Hall Rest Home has grown through the years in response to needs of elder citizens in the area.

Horace Wright, an industrialist from Springfield, contributed his estate to the community in 1944. Later, the Wright Town House Apartments were built adding a group of affordable 28 spacious, well-equipped apartments and common areas to the community.

Changes in insurance coverage, shorten hospital and nursing home stays and lack of extended family require patients to recuperate alone either at home or in other environments. The addition of a 90 unit living facility to the campus offers residents 60 years and over, Dignity, Choice, Independence and Support in a secure environment. This expansion brings to the Pioneer Valley the first program developed to provide appropriate urban housing with assisted living health programs, a wide range of community activities and the coordination of public government and private endowment revenue to maintain It affordable to our residents.

Also, this expansion illustrates the home's mission to reach out in a coordinated way to our elder citizens who find living alone very risky, but moving to a nursing home more care than necessary. The 90 apartment provides an integrated, comprehensive residential care setting offering elderly assistance with personal care, meals, housekeeping medication monitoring, 24 hour nursing supervision, recreational and social activities. In addition, apartments are wheelchair accessible, have walk in showers with seats, individual thermostats and air conditioners among other amenities.

The new facility is PRIMUS MASON COURT and, together with the Wright Town House Apartments will comprise the Mason-Wright Retirement Community. The maximum income requirement follows the Low-Income Tax Credit Program guidelines that are 19,500 for single individual and $22,250 for a couple, Assets are assessed but only the annual interest is included in the income guidelines. There is a selection of studio and one bedroom apartment available. There are three plans of care, A - minimal, B- moderate, and C- maximum. For example, a resident eligible for plan A and a Studio apartment would be paying as low as $787 a month. A resident eligible for plan C and 1 bedroom would be paying $1917 a month.

This residence comes at a perfect time for low and middle income seniors due to changes in Medicare, Health Care Maintenance Coverage, shorten hospital and nursing home stays and the loss and availability of the extended family.

If you have patients, relatives who require the care and are financially eligible or you would appreciate an inservice, please call me.

BRENDA BROWN, MARKETING COORDINATOR

413-733-1517

Calling for nominations for:

Hampden District Medical Society Award for "Community Clinician of the Year"

This new annual award is sponsored by the MMS and HDMS and **recognizes a physician who has made significant contributions to patients and the community.** Candidates must be members of the HDMS to qualify.

The award recipient chosen by their district colleagues to receive the ***Award for Community Clinician of the Year*** will be presented their Award at our Annual District Spring Meeting. In addition the award recipient will also be recognized at the Annual MMS Meeting held in May.

Please submit your nominations by January 31, 2000.

Submit nominations along with supporting letters to:

Suzanne Skibinski, Executive Director HDMS
Hampden District Medical Society
1111 Elm Street, Suite 22
West Springfield, Massachusetts 01089

The Hampden Hippocrat Newsletter
Hampden District Medical Society
1111 Elm Street, Suite 22
West Springfield, MA 01089-1540

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Please contact us with address changes at: 413-736-0661.